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Exhibit 284

A HISTORY

OF

THE DEVELOPMENT OF THE APPROVAL PROGRAM

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(The following summary of the development of the Approval Program of the)
(American Hospital Association has been developed from records in the)
(possession of the Blue Cross Commission and the American Hospital Asso-)
(ciation by the Staff of the Blue Cross Commission - - - November , 1951.)

The Blue Cross Approval Program as it stands today had its genesis in the seven "Essentials of an acceptable plan for group hospitalization" which was enunciated by the American Hospital Association's Council On Community Relations and Administrative Practice in September, 1933 and adopted as Association policy subsequently.

In January, 1937, the AHA established the Committee On Hospital Service which, under the names of Commission On Hospital Service and Hospital Service Plan Commission, was the forerunner of the Blue Cross Commission and was charged with promoting the application of the principle of group payment for hospitalized illness and improving the efficiency, scope, development and administration of non-profit hospital service Plans.

First Standards

The Committee On Hospital Service, with the counsel of an Advisory Group of five Plan executives, published the first Approval Standards in January, 1938 under the title "Standards For Non-profit Hospital Care Insurance Plans". It was on the basis of these Standards that the AHA first granted approval to (40) Plans as of April 1, 1938.

The Commission On Hospital Service Plans published a revision of the original standards, "revised to May 1, 1939", on April 28, 1939 under the title "Standards For Non-Profit Hospital Service Plans".

The next major revision of the Approval Program was contained in a brochure published in December, 1942, entitled "Approval Program and Standards for Blue Cross Hospital Service Plans".

Blue Cross Tied Into Program

Noteworthy in the 1942 brochure are these excerpts from the introduction:

"* * * The Trustees of the American Hospital Association in September, 1937, authorized the Committee On Hospital Service (now the Hospital Service Plan Commission) to recommend formal approval to non-profit Plans for hospital service which are organized in accord with these principles.

In 1941, the Approval Program became the direct responsibility of the Board of Trustees, as stated in Article VIII, Section 6, of the By-Laws of the American Hospital Association: ' The Board of Trustees shall establish standards for and administer program

of annual approval for organizations operating non-profit hospital service Plans which apply for such approval. The purpose of the Standards shall be to protect the interests of the subscribers, the medical profession, and the hospitals."

and

"Approval includes eligibility for Active Institutional Membership in the American Hospital Association; also permission to identify the Plan by using the seal of the American Hospital Association superimposed upon a Blue Cross. The approved Plans may, and often do, identify themselves in their respective communities as 'Blue Cross Plans'."

Under date of June, 1944, there was published the "Approval Program and Standards For Blue Cross Hospital Service Plans", representing the fourth revision of the original Approval Program.

New Approach In 1946

In September, 1946, the House of Delegates of the AHA adopted what was, up to that time, the most comprehensive revision of the Approval Program yet undertaken. The (1946) "Blue Cross Approval Program of the American Hospital Association" separated the standards into two categories, those for first approval and those for reapproval and added a final section of "Principles" to be accepted by Plans and hospitals in governing their relations.

The present Approval Program, adopted by the House of Delegates of the AHA in September, 1950, is the result of widespread effort on the part of the Blue Cross Commission and the American Hospital Association, committees and councils of each, and Blue Cross Plans to achieve a "practical" program. The present Approval Program consists of "General Principles", "Standards", and the previously mentioned "Principles" governing relations between Plans and hospitals.

Comparison Of Standards

A chronological comparison of the Standards and other points which have comprised the various Approval Programs may be of significance. The "Essentials" of 1933 were:

(1) Emphasis on public welfare
(2) Limitation to hospital charges
(3) Enlistment of professional and public interests
(4) Free choice of physicians and hospital
(5) Non-profit organization
(6) Economic soundness
(7) Cooperative and dignified promotion.

The first Standards (January, 1938), with one important exception, translated the "Essentials" into a series of 14 detailed provisions. If one were to include the sub-paragraphs, there were actually 24 provisions of the 1938 Standards. The one notable addition to the Standards was that provision of Standards 4 (a) which read as follows:

" (a) Benefits to subscribers should be guaranteed through 'service' contracts with member hospitals as opposed to 'cash' indemnification contracts for hospital expenses."

1939 Standards

The May 1, 1939 revision of the original Standards added a provision suggesting that "a majority of the policy-making body (of the Plan) be representative of hospitals." On the fiscal side, specific suggestions were made regarding percentages of income to be set aside for hospital expense and for reserves and administrative expenses.

1942 Standards

The December, 1942 Standards referred for the first time to the desirability of a Plan's serving the "largest possible geographic area that legal and economic conditions permit", gave notice that Plans applying for approval would not necessarily be approved if located in or near an area already adequately served by an approved Plan and set at 500,000 persons the minimal population of a Plan's trading area. Also, it was provided that there be "A definite understanding as to the territory in which each Plan enrolls * * *".

The 1942 Standards also were more specific regarding contracting hospitals and enrollment achievements. The Standards not only stated that contracts should be signed with hospitals representing a majority of the bed capacity in the area served, but also urged hospitals to enter into contracts with only one Plan, unless circumstances were extraordinary. It was also provided that service benefits be furnished subscribers by member hospitals of adjacent Plans "on some basis agreeable to both Plans". Lacking such an arrangement, it was urged that out-of-town allowances be adjusted to "amounts * * * equal or essentially equal to present per diem payments to member hospitals, not exceeding regular charges."

An attempt to set enrollment goals was indicated by the following provisions of several (1942) Standards:

> "* * * There should be reasonable prospect for the enrollment of at least 100,000 participants within five years following approval.
>
> For Plans which have been in operation one year, the total enrollment should exceed 10,000 participants; for those with two or more years' activity, enrollment should exceed 25,000 participants."

and

> "Where community response has been slow, as measured by enrollment, the Blue Cross Plans are advised to consider revision in their rates, benefits, enrollment methods, or public policies; also, the possibility of expanding their service by increasing the territory to be served or by merger with other Blue Cross Plans which might serve their respective areas more effectively."

1944 Standards

The June, 1944 Standards made a specific recommendation regarding initial working capital, stating in Standard No. 2 that it

> "should be sufficient to carry all acquisition costs and operating expenses for at least four months after contracts first become effective."

Standard No. 5 related enrollment to utilization in these words:

> "Enrollment practices shall be such as can reasonably be expected to assure a utilization approximating that of the general population and such as will not expose the Plan to adverse selection."

Standard No. 6 provided that the Commission

> "shall prescribe minimum standards of sound accounting practice,"

and

> "should also require each approved Plan to submit periodic reports of financial experience."

1946 Standards

In October, 1946, the House of Delegates of the AHA approved another revision of the Approval Program which amounted to a thorough overhauling of the Standards. Under Standards for initial approval, the following provisions were introduced:

> "In the absence of a provision in the hospital contract which establishes hospital responsibility for contract benefits, each Plan shall proceed to establish contingency reserves (over and above all liabilities) equal to at least 5 per cent of its previous annual income, beginning with the calendar year 1947, until such contingency reserves shall equal 25 per cent of the Plan's current annual income."

> "The Commission shall enforce minimum standards of sound accounting practices." (The previous Standards had used the word "prescribe" instead of "enforce".)

Whereas the previous Standards had stated that payments to hospitals "should be based on the costs of services", the 1946 Standards made no specific recommendation regarding method of reimbursement, merely stating that Plans and hospitals should work out mutually acceptable reimbursement methods.

Reciprocity with other Blue Cross Plans was urged, with particular reference to transfer of members, reciprocal benefits for members hospitalized out of their own Plan's area, and uniform procedures for handling national accounts.

The Standards for annual reapproval paraphrased the "original" Approval Standards and incorporated them by reference.

A set of "Principles Governing the Relationship between Hospitals and Blue Cross Plans" was added to the Approval Program in 1946. These "Principles" identified Blue Cross Plans as intermediary agencies representing the interests of both the hospitals and the public and urged that Plans and hospitals strive constantly toward the adjustment of mutual problems, each being sympathetic to the other's peculiarities of administration and refraining from making unreasonable demands.

1950 Standards

The present Approval Program, adopted by the House of Delegates of the AHA in September, 1950, resulted from more than two years of discussion, study and debate within the Blue Cross Commission, its committees, Annual Conferences of Plans, the Board of Trustees of the AHA and its councils and the House of Delegates. The present Approval Program was the result, moreover, of a specific request to the Blue Cross Commission and the AHA's Council On Prepayment Plans and Hospital Reimbursement to produce an Approval Program which would be more effective, more explicit and more readily enforceable.

The current Approval Program consists of four parts, if one includes the prefatory Part I. Introduction. Parts II. General Principles; III. Standards; and IV. Principles Governing the Relationship Between Hospitals and Blue Cross Plans are the important segments of the Program. Part IV. remains unchanged from the 1946 Program. Part II. consists of broad objectives, with the exception of General Principle 1 which ties use of the Blue Cross and the words "Blue Cross" into compliance with Part III. Standards.

Among basic changes in the Standards from previous Approval Programs are the following:

That at least one-third of the members of a Plan's governing board shall represent contracting hospitals and at least one-third shall represent the general public.

That a Plan shall cover under its most widely held certificate an average of not less than 75 per cent of the total amount (of the hospital bill) in the accommodations specified in the subscriber certificate for in-patients during the full coverage period.

That contingency reserves shall be sufficient to at least meet hospital and operating expenses for a three months' period.

That Plan-hospital agreements shall not be cancellable on less than 90 days' notice.

That no Plan employee shall be paid principally by commission or on a production fee basis.

That a Plan shall participate in all national programs in which at least three-fourths of the Plans representing also at least three-fourths of the weighted vote of all Plans are participating, unless such participation "would materially and inequitably" affect the Plan's operations.

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